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Policing the profession? Regulatory reform, restratification and the emergence of Responsible Officers as a new locus of power in UK medicine

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ABSTRACT

Doctors' work and the changing, contested meanings of medical professionalism have long been a focus for sociological research. Much recent attention has focused on those doctors working at the interface between healthcare management and medical practice, with such 'hybrid' doctor-managers providing valuable analytical material for exploring changes in how medical professionalism is understood. In the United Kingdom, significant structural changes to medical regulation, most notably the introduction of revalidation in 2012, have created a new hybrid group, Responsible Officers (ROs), responsible for making periodic recommendations about the on-going fitness to practise medicine of all other doctors in their organisation.

Using qualitative data collected in a 2015 survey with 374 respondents, 63% of ROs in the UK, this paper analyses the RO role. Our findings show ROs to be a distinct emergent group of hybrid professionals and as such demonstrate restructuring within UK medicine. Occupying a position where multiple agendas converge, ROs' work expands professional regulation into the organisational sphere in new ways, as well as creating new lines of continuous accountability between the wider profession and the General Medical Council as medical regulator. Our exploration of ROs' approaches to their work offers new insights into the on-going development of medical professionalism, pointing to the emergence of a distinctly regulatory hybrid professionalism shaped by co-existing professional, managerial and regulatory logics, in an era of strengthened governance and complex policy change.

1. Introduction

Doctors' work and the changing, contested meaning of medical professionalism have long been a focus for researchers, and in recent years the medical profession's place in relation to reconfigured models of healthcare management and governance has generated extensive interest. Much attention has centred on those doctors working at the interface between healthcare management and medical practice, and has demonstrated that such 'hybrid' doctor-managers provide valuable analytic material for exploring changes in how medical professionalism is understood (Kuhlmann et al., 2013; McGivern et al., 2015; Noordegraaf et al., 2016; Waring, 2014). Such work has recognised, amongst some international commonalities, the importance of significant national specificities, particularly when analysing relationships between professionals and states or organisations (Bezes et al., 2012). Here, we seek to add to such critiques by exploring the implementation of regulatory reforms in the United Kingdom (UK), which have, for the first time, placed considerable statutory powers and duties in the hands of a nominated medical professional in each organisation employing or contracting with doctors, formally titled the 'Responsible Officer' (RO).

First, we set out the background and context to this development, describing in overview the nature of the reforms leading to these changes. We then draw on theories of professional restratification, Foucault's concept of governmentality (Foucault, 1991), and research on hybrid professionals to frame our analysis of the RO role, with a particular focus on their responsibility for the implementation of medical revalidation, a new regulatory mechanism in place since 2012. Using this theoretical framework, this paper analyses qualitative data from a national survey of ROs, and discusses the insights these new hybrid professionals offer for understanding professional responses to

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regulatory reform.

1.1. Regulatory reform and the medical profession

The creation of the RO role, and the introduction of revalidation, notably changed how medical practice in the UK is regulated; the latest in a series of policy shifts affecting the governance of the medical profession. Historically, medicine operated a model of self-regulation both formally and informally, at group and individual levels (Chamberlain, 2009). Practitioners were expected to regulate themselves by practising in accordance with shared professional standards (Waring, 2007). Since 1858, the General Medical Council (GMC) has controlled professional registration, and assured standards of medical education. Through its Fitness to Practise (FTP) procedures, the GMC investigates allegations of poor performance or misconduct. However, traditionally much management of poor performance occurred locally and informally, relying on collegiate discussions and 'in-house' resolution rather than formal regulatory mechanisms (Rosenthal, 1995). Moran (2003) characterised this as 'club regulation', a lasting expression of the Victorian regulatory state, focused on maintaining good relations within the profession. The profession was thus entrusted with regulating its membership by the state and society, in a 'a neat and powerful arrangement' (Salter, 2001).

Latterly, however, this arrangement has altered dramatically, with a move towards bureaucratic regulatory oversight (Waring et al., 2010), pointing to some erosion of professional autonomy (Dixon-Woods et al., 2011), and the profession no longer solely responsible for its own regulation. Broad consensus exists on the contributing factors that converged to politicise medical regulation and create an appetite for change. First, since the 1980s, successive governments' adoption of neoliberal New Public Management (NPM) principles extended state interest in healthcare delivery and organisation, and consequently in monitoring clinical standards (Waring et al., 2010). Concurrently, emergent patient groups (Mold, 2010) contributed to scepticism about medical authority (Salter, 2001). Finally, high profile malpractice scandals in the 1990s and 2000s raised doubts about the profession's ability to self-regulate effectively (Dixon-Woods et al., 2011; Salter, 2007; Waring, 2007). Consequently, in the 2000s, the GMC was reconstituted to reduce medical dominance, and gained powers to oversee not just professional misconduct but poor performance.

The changed political mood added impetus to long-mooted plans for revalidation (Archer et al., 2015), accompanied by the creation of the RO role, whose origins lay in GMC proposals that revalidation should entail local certification of doctors' participation, by an organisational representative, such as the Medical Director or Chief Executive (Smith, 2004). Following the Shipman Inquiry's criticism of GMC plans, strengthened new proposals, more clearly defining the responsibilities associated with local assurance of revalidation, and assigning these to a specific new RO role, were set out by the Chief Medical Officer (Department of Health, 2008). Subsequent legislation (Health and Social Care Act, 2008) required organisations employing or contracting with doctors to appoint an RO before revalidation was introduced in 2012.

1.2. Responsible Officers and regulation

Revalidation aims to monitor doctors' fitness to practise throughout their careers. Comparable schemes exist or are under consideration internationally (Boulet and van Zanten, 2014; Sehlbach et al., 2018), marking a notable trend towards continuing assessment of competency. However, the RO role is a striking feature of the UK medical regulatory system, when compared to others internationally (Archer and Regan De Bere, 2013).

Revalidation requires doctors to document their practice and participate in annual appraisals (General Medical Council, 2012). Their RO then brings appraisal information together with other clinical governance data to make a formal recommendation to the GMC, usually every fifth year (General Medical Council, 2015). ROs may recommend that doctors be revalidated, or that their revalidation be deferred, or notify the GMC that the doctor has not engaged. Using this recommendation, the GMC decides whether to renew the doctor's licence to practise.

Greenhalgh and Wong (2011) described the revalidation process as essentially technical and bureaucratic, aligned with scientific-bureaucratic medicine, including increased managerialism. Its introduction was contested from within the profession (Archer et al., 2015), due to fears of its reductive impact on professional autonomy and the challenge of reconciling formative appraisal processes with a summative regulatory mechanism (Archer et al., 2017). Subsequently, amongst those in leadership positions at least, previously conflicting discourses of professionalism and regulation have converged, driven by the legislative imperative to implement the policy (Tazzyman et al., 2018). However, positioning revalidation as a policy move from embodied trust in professionals to state enforceable trust, Spendlove (2018) identified continued professional resistance manifested in doctors' formalistic approaches to engagement.

The approximately 600 ROs are intrinsic to this regulatory process and must also monitor the fitness to practise of doctors connected to their organisation (The Medical Profession (Responsible Officers) Regulations, 2010). They work for organisations ranging from those with just a few connected doctors to those with several thousand, across NHS, independent and third sector settings (NHS England, 2016). In most cases, the role is held by the Medical Director (MD) or Deputy Medical Director. Some, often smaller, organisations contract out the role, and some ROs fill the role for multiple organisations.

1.3. Interpreting professional responses to regulatory reform

Existing research on ROs has typically focused on the practicalities of their work, particularly during early implementation (Nath et al., 2014; Shepherd and Cameron, 2010; Webster and McLachlan, 2011), or on their own experiences of undergoing appraisal (Furmedge et al., 2016; Griffin et al., 2015). In this paper, we analyse the RO role in the light of theoretical interpretations of comparable hybrid doctor-manager groups, to better understand their position at the interface of this fundamentally changed relationship between medical regulation and healthcare organisations.

In some quarters, the curtailment of professional self-regulation has been seen, alongside increased managerial scrutiny of medical work, as having fundamentally undermined professional autonomy, as part of an international trend of 'deprofessionalization' (Bezes et al., 2012; Schlesinger, 2002). The diffusion of NPM principles brought an expansion of non-medical management in healthcare and new systems of performance management and financial control of medical practice (Ackroyd et al., 2007). However, as Le Bianic (2012) notes, analyses focusing solely on reduced autonomy position professionals as 'passive agents of reform' and 'frontally opposed' to managerialism. Alternative analyses have foregrounded more active professional responses to this changed political and social environment. Particular attention has focused on the emergence of clinical managers as new professional elites operating at the intersection between the medical profession and organisations (Cascón-Pereira et al., 2016; Correia and Denis, 2016; Kuhlmann et al., 2013; Martin and Waring, 2013). Such 'hybrids' (McGivern et al., 2015) offer insights how the medical profession has responded to regulatory and organisational reforms. Theoretical interpretations have centred on two concepts: restratification and governmentality.

Developed in response to the perceived threat of deprofessionalization, the restratification thesis (Freidson, 1985, 1994, 2001) posited that elite groups would operate oversight and control over the mass, or 'rank and file', of their profession. For Freidson, professionalism was a 'third logic' by which professional work may be controlled, existing